STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Annaliese L. Krzyzanek
Careing Hands Adult Family Home
8610 W Bruneau Ave
Kennewick, WA 99336

RE: Careing Hands Adult Family Home License # 752706

Dear Provider:

This letter addresses Compliance Determination(s) 58744 (Completion Date 04/30/2025) and 56267 (Completion Date 03/25/2025).

The Department completed a follow-up inspection of your Adult Family Home on 04/30/2025 and found that you have corrected the violations listed in the Complaint report dated 03/25/2025. Your home is back in compliance as of 04/10/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10400-2, WAC 388-76-10400-4

The Department staff who did the on-site verification:
Sarah Clark, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Ann Yarbrough

Michelle Yarbrough, Adult Family Home Field Manager
Region 1, Unit C
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 03/13/2025 of:

Careing Hands Adult Family Home
8610 W Bruneau Ave
Kennewick, WA 99336

This document references the following complaint number(s): 171001

The following sample was selected for review during the unannounced on-site visit: 2 of 6 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Sarah Clark, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit C
1200 Alder Street
Union Gap, WA 98903

Statement of Deficiencies	License #: 752706	Compliance Determination # 56267
Plan of Correction	Careing Hands Adult Family Home	Completion Date
Page 2 of 7	Licensee: Annaliese L. Krzyzanek	03/25/2025

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Michelle Ann Garbrough
Residential Care Services

04/04/2025
Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative)

4-9-2025
Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to provide necessary care and services to prevent skin breakdown and promote healing and failed to obtain nurse delegation prior to completing delegated tasks for 1 of 3 residents (Resident 1). These failures resulted in worsening skin breakdown and resulted in unqualified caregivers completing nurse delegated tasks for the resident.

Findings included...

Observation, on 3/13/2025 at 7:10 AM, showed Resident 1 was in their bed and was positioned slightly onto their left side. Staff A, Caregiver, administered a pain medication crushed in yogurt. Resident 1 did not open their eyes during the interaction and was unable to communicate their needs to Staff A.

On 03/13/2025 at 8:03 AM, Staff A was observed providing personal care to Resident 1. A dressing was observed on Resident 1's sacrum (base of spine) and the dressing was wet with urine. There was an additional wound on Resident 1's right hip wound that was covered with a clean dressing. A circular reddened area was noted on Resident 1's left hip. Resident 1 was thin and had no visible body fat. Resident 1 was positioned on their

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Residential Care Services | Date

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Provider (or Representative) | Date

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Findings included…

Observation, on 3/13/2025 at 7:10 AM, showed Resident 1 was in their bed and was positioned slightly onto their left side. Staff A, Caregiver, administered a pain medication crushed in yogurt. Resident 1 did not open their eyes during the interaction and was unable to communicate their needs to Staff A.

On 03/13/2025 at 8:03 AM, Staff A was observed providing personal care to Resident 1. A dressing was observed on Resident 1’s sacrum (base of spine) and the dressing was wet with urine. There was an additional wound on Resident 1’s right hip wound that was covered with a clean dressing. A circular reddened area was noted on Resident 1’s left hip. Resident 1 was thin and had no visible body fat. Resident 1 was positioned on their

left hip with their legs leaning to the left side of the bed. An alternating pressure pad (a specialty air mattress) was on Resident 1's bed. Resident 1 required was total assistance from Staff A for all care provided.

Review of the AFH's undated Disclosure of Services showed the AFH specialized in dementia, providing care 7 days a week/24hours and indicated the home offered total incontinent care, and all positioning assistance provided. The home offered skilled nursing services by delegation including medication administration, diabetic blood sugar checks, insulin injections, oxygen, eye drops, and ointments. The Disclosure of Services showed normal staff levels were a Registered Nurse on call 24/7 and certified nursing assistants or long-term care workers available 24/7. The Disclosure of Services also showed the home offered total incontinent care, and all positioning assistance provided.

Review of Resident 1's assessment, dated 08/07/2024, showed Resident 1 was receiving palliative care (specialized medical care that provides relief from symptoms of serious illness). Resident 1 was incontinent of urine, had no skin problems, walked with weight bearing support of 1 person, was able to support their own weight and required hands on guiding during transfers, using a walker and wheelchair.

Review of an additional assessment, dated 08/07/2024, provided to the Department on 03/25/2025, indicated Resident 1 was on palliative care. Resident 1 had no skin issues, ambulation was limited due to weakness, unable to assist with transfers, used a wheelchair, and required set-up, monitoring and encouragement for eating/drinking.

Review of the Hospice team care plan, dated 09/05/2024, showed Resident 1 had a diagnosis of [redacted] ([redacted]) with [redacted], [redacted], [redacted] ([redacted]), [redacted] and [redacted]. Resident 1 was incontinent of bowel and bladder, non-weight bearing, complete bedrest, was disoriented and lethargic. The care plan stated the AFH staff would communicate and collaborate with the hospice team regarding Resident 1's care needs.

Review of Resident 1's Negotiated Care Plan (NCP), dated 08/26/2024, was not present in the AFH when the Department visited the AFH on 03/13/2025. The NCP was provided to the Department on 03/13/2025 at 3:25 PM and showed Resident 1 had a bedsore, in an unspecified location, and was on hospice. The NCP had no further documentation or updates regarding Resident 1's wounds, treatments, or interventions given by hospice provider.

NCP specified in the following sections:
- Specialized body care –Caregiver will monitor entire body for signs of redness, pressure wounds, or other skin breakdown and report to physician and delegating nurse. Skin integrity will be maintained. Caregiver staff will maintain good skin care.
- Toileting - Full Assistance required – Caregivers will change Resident's 1 depends frequently through the day and night if needed. Caregiver will properly clean resident's

skin after each bowel movement and voiding.
- Ambulation – Full assistance required – Resident 1 is full assistance and bed bound.
- Repositioning – Full assistance required –Caregiver will turn and position Resident 1 if needed and record in system. Resident will be able to relocate and reposition as needed or desired and skin integrity will be maintained. Resident will be able to assist in repositioning.
- Skin problems/wounds – Caregiver will assist with clean technique for wound care as ordered by MD and delegated by delegating nurse. Caregiver will monitor for signs of infection and will report negative changes to MD and nurse delegator in a timely manner.

Review of hospice nursing visit notes, located in Resident 1's chart indicated as follows:
- Visit record instruction sheet, dated 12/11/2024, with plan/instructions: barrier cream to sacrum/coccyx (tailbone), turn positions every two hours, keep dry. Signed by Staff A.
- Visit record instruction sheet, dated 01/15/2025, with plan/instructions: noted 2-centimeter (cm) x 2 cm pressure wound to sacrum. Signed by Staff A.
- Visit record instruction sheet, dated 03/05/2025, with plan/instructions: new wound to right hip 1.5 cm x 1 cm. Signed by Staff A.

Review of hospice clinical chart notes showed the following:
- Note dated 12/04/2024, showed Resident 1 was incontinent of bowel and bladder, dependent for Activities of Daily Living (ADLs). Resident 1had a new wound to the right side of their sacrum and was dependent for activities of daily living. Instructed to apply barrier cream and change position every two hours.
- Note dated 12/11/2024, showed Resident 1 had a stage II pressure wound to their sacrum, staff was applying barrier cream. Education to keep Resident 1 dry and change positions every two hours with an un-named caregiver verbalizing understanding.
- Note dated 01/02/2025, showed wound was healing, education provided on turning and repositioning every 2 hours.
- Note dated 01/08/2025, showed the caregiver reported the wound remained the same. The nurse educated on turning, repositioning and keeping Resident 1 dry with Staff A verbalizing understanding.
- Note dated 01/15/2025, showed wound (sacrum) remained the same with non-blanchable redness to right hip. Education on turning and repositioning every two hours.
- Note dated 01/29/2025, showed Resident 1 had no meaningful conversation, was incontinent of bowel and bladder, was dependent for all ADLs, and had a stage II pressure ulcer to their sacrum measuring 2 cm x 2 cm. The note also, indicated Resident 1 had increased pain requiring more doses of pain medication.
- Note dated, 02/13/2025, showed wound to sacrum was getting bigger and measured 3 cm x 2 cm.
- Note dated 03/05/2025, showed Resident 1 had a new pressure wound to their right hip measuring 1.5 cm x 1 cm. Education provided with Staff A to turn and reposition Resident 1 frequently and keep them as dry as possible.
- Note dated, 03/12/2025, showed Resident 1's wound to sacrum and hip were not improving with non-blanchable redness to left hip and a possible 3rd pressure wound.

When asked Staff A about skin issues and turning and repositioning, Staff A reported to hospice nurse Resident 1 was not being turned or changed at night and usually soaked up to their neck with urine when Staff A came on in the morning.

Review of a hospice physician order, dated 03/12/2025, instructed
to turn and reposition Resident 1 every two hours to prevent skin breakdown.

During an interview on, 03/13/2025 at 6:49 AM, Staff A, stated Resident 1 was normally incontinent with urine when they start their shift. Staff A was not certain if Resident 1 had been checked on through the night, as AFH staff sleep during the overnight shift. Staff A did not know when night staff checked on residents overnight. Staff A also stated Resident 1 could not use their call light or make their needs known for any care needs.

During an interview, on 03/13/2025 at 9:22 AM, Staff B, Provider, stated if a resident needed nighttime care, they would talk about it with the resident or family and care plan the nighttime care. Staff B further stated they could accommodate a resident who needed to be checked and changed through the night.

During an interview, on 03/13/2025 at 9:39 AM, with Staff C, Caregiver, they stated they worked nights. Staff C stated they got up about twice a night and checked on residents. Staff C stated they have sometimes done incontinent care on Resident 1 and sometimes reposition them a little.

On 03/18/2025 at 3:00 PM, Staff B stated care tasks would be documented in their system if Resident 1 was being repositioned every two hours and they did not believe Resident 1 was getting repositioned at night. They also stated if hospice would have told them or their staff that Resident 1 needed to be woken up and turned every two hours, they would put it into the care plan. Staff B also stated Resident 1's hospice provider would no longer provide Resident 1 care in the AFH and Resident 1 would be moving on 03/19/2025. Staff B stated they were not given a reason explaining why hospice could no longer provide care to Resident 1 in the AFH.

Review of Resident 1's chart notes there was no documentation, from night shift, from December 2024 to March 2025 indicating that Resident 1 was checked on, repositioned, or provided incontinent care.

On 03/18/2025 at 3:32 PM, Collateral Contact 1(CC1), Resident Representative, stated since Resident 1 developed the wounds, the resident needed repositioning every 2 hours. CC1 understood that Resident 1 was turned and repositioned on evening shift then left sleeping until morning. CC1 did not think Resident 1 was repositioned or changed during the night. CC1 also stated Resident 1's wounds would worsen over the weekend and felt that staff were not being diligent with repositioning Resident 1. CC1 further stated that Resident 1 would be discharging from the AFH on [redacted]/2025 as the

hospice team determined Resident 1 needed more care than could be provided at the current AFH.

During an interview, on 03/21/025 at 1:37 PM, Collateral Contact 2 (CC2), Nurse Delegator, stated they last completed an assessment for Resident 1 in August 2024. CC2 reported the AFH had not contacted them to request a significant change assessment.

During an interview on 03/24/2025 at 3:41 PM, Collateral Contact 3 (CC3), Hospice Nurse, stated Resident 1 did not have any wounds when they admitted to hospice in August 2024. CC3 reported the first wound appeared in December 2024, and additional wounds developed in the following months. CC3 stated all the wounds were on high pressure areas. CC3 stated they sent the hospice wound care nurse a picture of Resident 1's sacral wound. The wound care nurse was concerned the wound was too moist.

<Nurse Delegation>

Observation on, 3/13/2025 at 8:03 AM showed Staff A, Caregiver, cleaned Resident 1's sacral wound, applied a piece of silver collagen matrix (a dressing designed to promote wound healing), and covered with a bordered gauze dressing.

During an Interview, on 3/13/2025 at 11:50 AM, Staff A, stated Resident 1's hospice nurse showed them how to do the wound care and there was no nurse delegation paperwork.

During an Interview, on 03/13/2025 at 11:49 AM, Staff B, stated they did not have any paperwork on nurse delegation for wound care.

On 03/13/2025 review of Resident 1's records showed there was no documentation to show that nurse delegation had been completed for the wound care.

Review of a hospice physician order dated 02/26/2025, instructed that the sacral wound was to be cleansed, dried, silver collagen applied to wound bed, and covered with dressing once daily.

Review of a hospice physician order, dated 03/05/2025, instructed that the right hip wound was be cleansed, dried, silver collagen applied to wound bed, and covered with dressing once daily.

During an interview on 03/21/2025, Collateral Contact 2 (CC2), Nurse Delegator, stated

Statement of Deficiencies	License #: 752706	Compliance Determination # 56267
Plan of Correction	Careing Hands Adult Family Home	Completion Date
Page 7 of 7	Licensee: Annallese L. Krzyzanek	03/25/2025

they did not delegate any wound care for Resident 1 and had not been asked to do so by the AFH.

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Careing Hands Adult Family Home is or will be in compliance with this law and / or regulation on
(Date) 4-9-2025

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative) — Date: 4-9-2025

Plan: Have better Communication between Hospice nurse & staff when it comes to wound care/delegation & updating the care plan

4-9-2025

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